SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

August Report Out Webinar
Depression and SBIRT Management

Nick Szubiak
Director of Practice Improvement

Setting the Stage:
Today's Moderator

Madhana Pandian

Associate

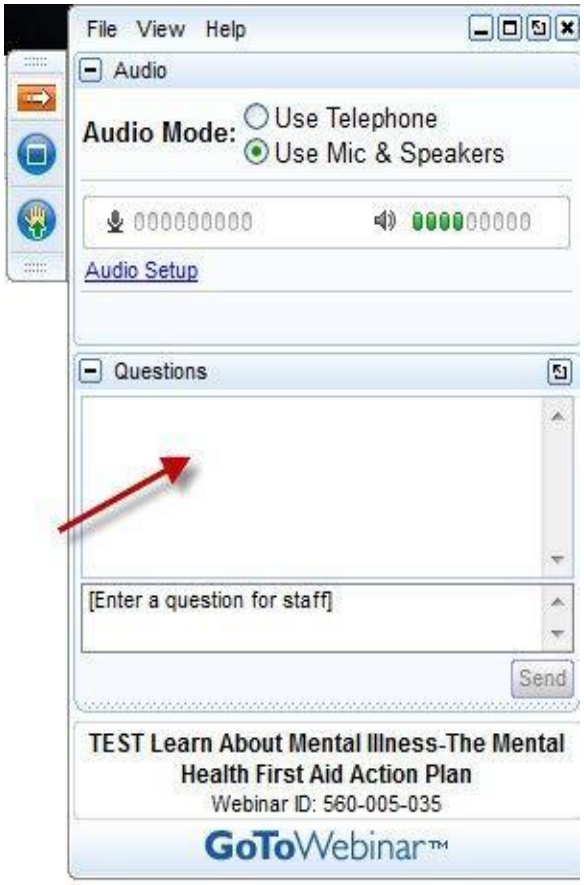
SAMHSA-HRSA Center for Integrated Health Solutions

Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov

Under About Us/Innovation Communities

Our format…



Structure

Short comments from experts

Specifics from their point of view

Polling You

Every 20-minutes

Finding the “temperature” of the group

Asking Questions

Watching for your written questions

Follow-up and Evaluation

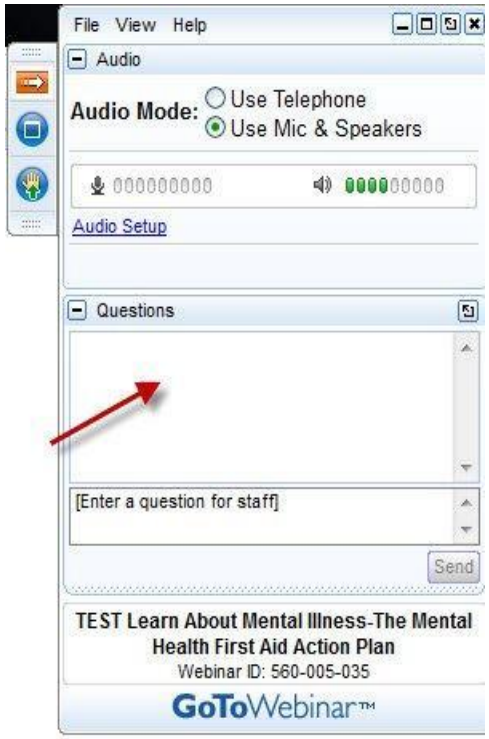
Ask for what YOU want or expect

Ideas and examples added to the AOS Resource Center

How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Listserv

Look for updates from:

bh_integration_ic@nationalcouncilcommunities.org

Evaluation

Due today to

madhanap@thenationalcouncil.org

Setting the Stage:
Today's Facilitator

Nick Szubiak

Integrated Health Consultant

SAMHSA-HRSA Center for Integrated Health Solutions

Final Two Webinar Report Outs

- Pick one action item to present on that you successfully impacted
- Tell us your story - We want to hear about how you did it
- Show us the data – pick one area you can use data to show us an outcome, change, or impact. How did your data become knowledge? Change? Or both?
- Think of presenting for 1-2 minutes per slide.

Harbor Care Health and Wellness Center

MEDICATION ASSISTED TREATMENT TEAM

NASHUA, NEW HAMPSHIRE

COMMUNICATION IMPROVEMENT

The WHO - two affiliated agencies who are providing substance use and mental health treatment opportunities.

The WHAT – referrals and care coordination (and, as a result, patient care) were negatively impacted as phone calls were missed or received too late.

The WHY – this resulted in a delay in admissions to programs or receipt of medical care. It was critical that we change this process.

COMMUNICATION IMPROVEMENT
OUR STORY

- We developed a shared folder on our hard drive that could be accessed by both agencies related to these patients and their care.
- We notified each other by phone and email to report an incoming patient, but then shared the vital care coordination documentation immediately.
- Challenges – getting staff to initially remember to use the new spreadsheet and continue to update the information.
- Resolution/Buy-in – Weekly Team meetings to change the culture and understand the impact on treatment through this change.

DATA

- Prior to MAT Team – 0 patients were tracked for follow up services that were being performed.
- Subsequent to MAT Team – 13 patients have been added to the shared folder for tracking since April 2016.
- Example of tracking data:

Name:	Date:	Referral Source	Referral To:	Inatke Appt Date	Patient Attended y/n	Next steps:	Admission date:
Does, Jane	4/1/2016	Name, Staff	Keystone/ IOP	5/11/2016	y	Waiting for bed, will attend intake meetings	Admit date set for 5/23/2016

Kokua Kalihi Valley Health Center (KKV)

Monica Tatekawa-Chen, PsyD
Clinical Psychologist
Integrative Behavioral Health Program
Honolulu, Hawaii

Action Item:
Depression Screening in Primary Care

- **The Target**
  - Increasing routine screening for Depression in the Primary Care Clinic
- **The What:**
  - Using a Standardized BH screening tool as part of the routine workflow during medical visits every 3 months
- **The Why:**
  - Increase collaborative care with PCPs; HRSA grant and UDS requirements; financial sustainability; improve quality of care

How We Did It…..

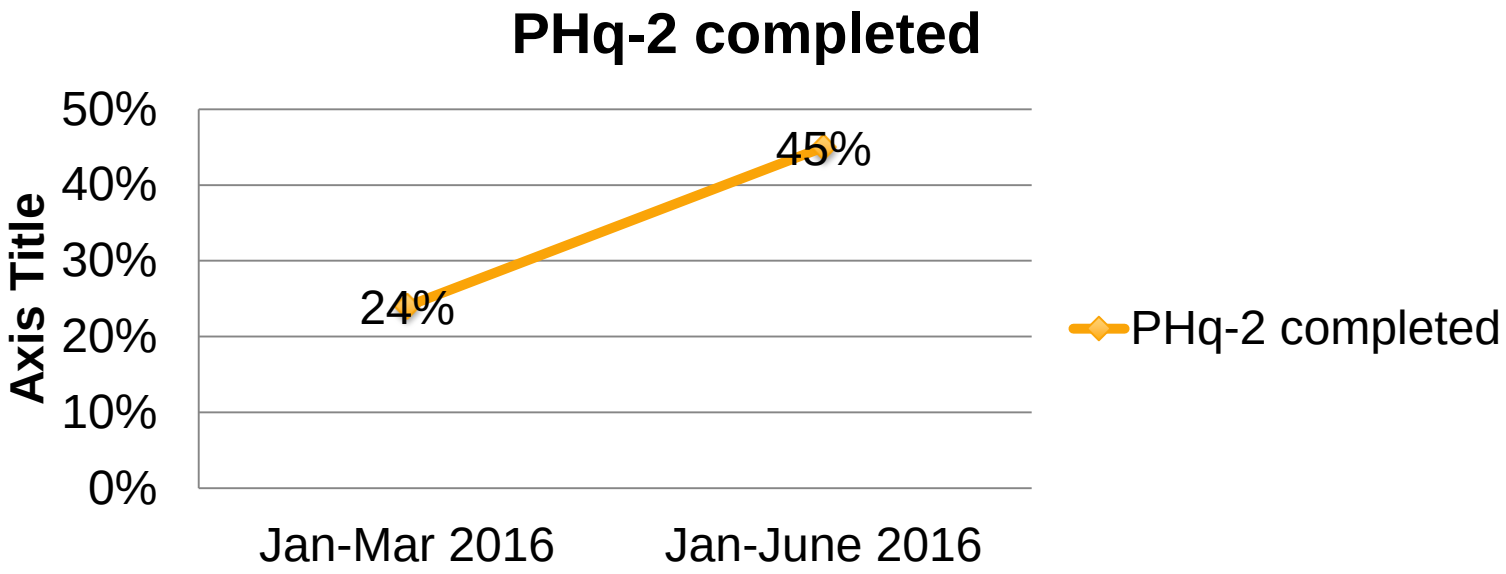
The Challenge: **"We have all these things we have to do during the visit and now you want us to also ask them about depression too?"**

- Time
- Buy in from the Medical Team (PCPs and MAs)

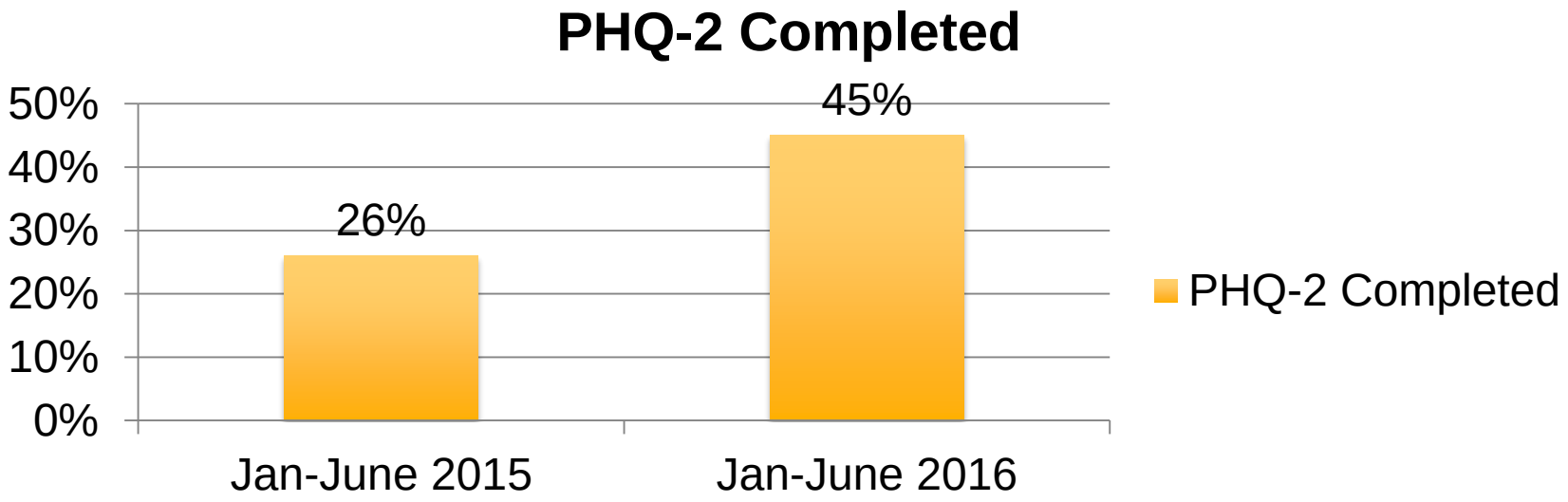
How We Did It…..

- Presented data during monthly Provider's meeting
- Met with MAs monthly
  - Devise a monthly "lucky drawing" for MA's (more positive screens, more names in the drawing)
- Identified new IBH champions (MA and PCP)
- Utilized our own IBH MA to assist with our Medical Care Teams

Kokua Kalihi Valley Health Center (KKV)



Kokua Kalihi Valley Health Center (KKV)



Mary's Center

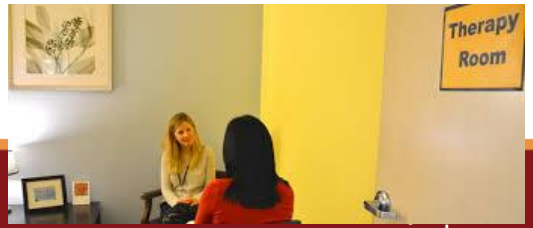
Mary's Center is a nonprofit organization based in Washington, D.C., and Maryland, with more than two decades of experience providing medical, social, and education services to families throughout the region.

Mary's Center Integrated Behavioral Health Team:

Delmy Alvayero, Gretchen Gates, Molly Hewes, Elba Rivas

4 Clinics in Washington, DC and Maryland:

Georgia, Ontario, Adelphi, and Flower…Soon to add a 5th at Ft. Totten



Action Item: Improve Referral Mechanism!!

- Prior to IBH implementation:
  - No consistent referral system
  - Not able to track referrals for outcomes data – came in form of e-mail, telephone, etc.
  - Referrals for ALL behavioral health concerns went to outpatient MH clinic
- Used organizational assessment to identify need for improved referral mechanism and implementation of IBH services

What Did We Do?

- **Step One**: Used EMR system (eCW) to create referral template and “buckets” to capture and triage clients for appropriate level of care
- **Step Two**: Worked with Outcomes team to create monthly reporting mechanism to track and analyze data
- **Step Three**: Hire & train IBH staff across all sites
  - Historically only had IBH at MD sites due to grants/funding
- **Step Four**: Train providers at all sites on IBH and new referrals system
  - Met with some resistance: CHANGE IS SCARY!
- **Step Five**: Implement IBH and warm hand-offs! Triage clients for appropriate level of care! Track referrals! Analyze data!

Data

Referrals & WHO's	Apr-16	May-16	Jun-16	Total
MH Triage Georgia	19	53	44	116
MH Triage Ontario	23	48	33	104
MH Triage Maryland	22	16	13	51
Warm Hand-Offs (all sites)	99	116	94	309
Total IBH Referrals				580
MH Therapy Referrals	21	28	10	59

Interpretation

- Previously, all referrals for participants with behavioral health concerns were sent to our outpatient behavioral health clinic, creating a waitlist for services. Therefore, IBH & triage is having a dramatic and favorable impact on being able to support Mary's Center participants recognized by other MC staff to be experiencing behavioral health issues.
- A much larger volume of Mary's Center participants with behavioral health issues are being referred to an IBH provider for further assessment.
- IBH is able to effectively triage participants referring only the neediest, most appropriate, and most engaged participants for services in our outpatient behavioral health clinic or to other higher levels of care.

High Country Community Health

Jennie Goodwin & Michael Streppa
High Country Community Health
Boone, NC

Action Item

What aspect of your action plan do you want to highlight?

Improving screening rates of both new patients at the time they establish care and existing patients at least once annually.

The who, what and why:

Care Teams, Front Desk staff and QI

PHQ-9, AUDIT, DAST (SBIRT model)

Part of our PCMH Practice Transformation

Tell us your story

- We want to hear about how you did it! What were the challenges you overcame; how do you use your individual and organizational creativity and uniqueness to solve, overcome, change, influence, implement?
- Our Challenges:
- EHR system limitations made data analysis tedious and time consuming
  - We discovered data entry problems/omissions that resulted in inaccurate data and are in the process of correcting – 8000 inactive patients were being included in many reports we had been running.

Tell us your story: Challenges, Continued

- EHR system limitations made data analysis tedious and time consuming
- Our QI Director left the organization, leaving a 6 month gap without a person in that position. Position was eventually combined with the nursing supervisor position. This person now has multiple roles and this has slowed data analysis
- We discovered a breakdown in care team communication that resulted in a lack of documented follow-up for positive screens. This documentation is still being free-texted by the medical providers, necessitating manual chart audits until we can correct this problem

Tell us your story

- Changes Made:
- We combined PHQ-9, AUDIT and DAST measures on one doubled sided form. This improved the completion rates of all three measures and kept all data in one place.
- Created templates in the EHR that made data entry faster; set alerts when annual screening was due for update
- Care team turnover adversely impacted initial stages of process. Once hired, a new BHC was able to work consistently with medical providers on follow-up for all positive screens. This is now standard practice.

Tell us your story

- Implemented weekly treatment team meetings and daily huddles early in 2015 and tweaked content and process over time.
- Hired a QI Director; began providing care teams with monthly data and then utilized staff meetings to address systems and process barriers
- Clarified staff roles and responsibilities; Care teams, front desk, QI

Depression Screenings

Patients 12 and older with one more visits 2015: *2869; 2016 YTD: *2239

(*Figures do not include sliding scale/self-pay patients; subtracted out because current EHR report only includes patients with payer source)

Goal: 55% (from 0 at beginning of 2015)

Quarter 1: 14% (189)

Quarter 2: 40% (545)

Quarter 3: 66% (933)

2016 Quarter 2: 93% (2093 of 2239)

Depression Screening Follow-up: Goal: 60%

2015 Quarter 3: 78% (Average follow-up rate for the year: 48%)

AUDIT & DAST Screenings

Patients 12 and older with one more visits 2015: 2869; 2016 YTD: 2239
(Figures do not include sliding scale/self-pay patients; subtracted out because current EHR report only includes patients with payer source))

Patients Screened: AUDIT & DAST (2366 in 2015; 2093 in 2016)

Goal: 55% (from 0 at beginning of 2015)

Quarter 1: 14%

Quarter 2: 40%

Quarter 3: 66%

2nd Quarter 2016: 93%

Documented Follow-up data not available at time of report

Tobacco Screenings

- pick one area you can use data to show us an outcome, change, or impact. How did your data become knowledge? Change? Or both?

Percentage of patients over 18 yrs. old screened for tobacco use:

2015 Goal: 95%

Quarter 1: 54%

Quarter 2: 60%

Quarter 3: 63%

2016: Quarter 1: 87%

Behavioral Health Integration Team

Lāna'i Community Health Center

The Island of Lāna'i

Action Item

Development of the stress questionnaire

Why- Our existing multiple screening questionnaires (Depression, Alcohol, Domestic Violence and Smoking), which are administered by the MAs as part to check-in, had limited value as the patients and MAs rushed through the questions.

Who and What- Behavioral Health Integration Team was to develop a unified questionnaire that would identify more than depression related to BH issues and combine substance abuse, chronic pain and alcohol use in a **single** questionnaire. The Team was also tasked with developing a better workflow to allow patients to answer honestly and increase our staff workflow efficiency.

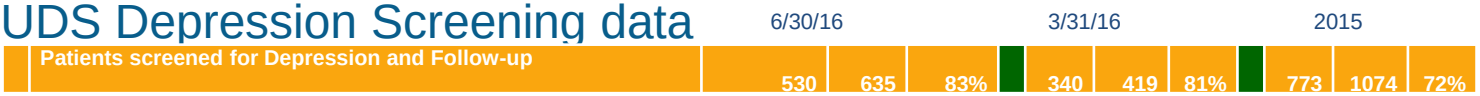
Tell us your story

What We Accomplished

- Developed a stress questionnaire using validated survey tools that combined the screening elements we wanted to collect by reviewing and selecting the best tools for our setting.
- Electing to use a tablet questionnaire to capture data rather than paper or oral and computer scoring. We used our care management software as the platform for the survey allowing for scoring. A PDF copy is placed in each patient's EHR.
- Improved efficiency of workflow with self-administration of the stress questionnaire being completed when the patient arrives, with MA assistance in reading the questionnaire or with the MA or provider asking and marking the tablet for the patient. Our plan is to administer the questionnaire once a year, or as needed, and have an alert in the care management software .

Show off your data !

- Challenges include completing the implementation.
  - There were delays in completing the survey configuration within the software, and in completing the MAs and other clinical staff training on using the survey tool.
  - We lost one of our Behavioral Health Providers during this project, which created a staffing shortage that has impacted our ability to move forward as quickly as planned.
- We are currently doing PDSA cycles to improve our workflow and are confident that we will be more effectively identifying patient with both BH problems and substance abuse.
- We are currently identifying ways to report our SBIRT data. Below is our UDS Depression Screening data



Middletown Community Health Center, Inc.

Kimberly Youchah, LMSW
Middletown, NY

Action Item

❖What aspect of your action plan do you want to highlight?

We felt that it would be beneficial to revamp our patient history forms that are required annually, to include the: PHQ-9, AUDIT-C, and DAST screenings.

❖The who, what and why?

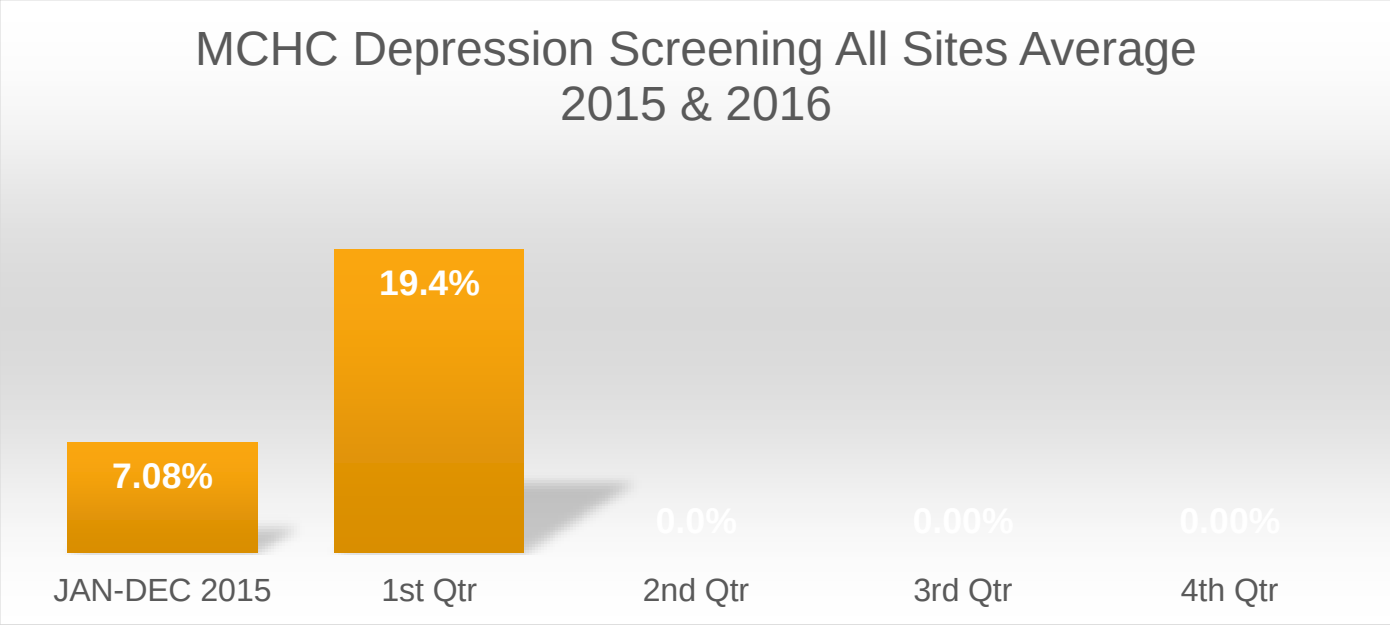
The data team worked with the Chief Medical Officer and Director of Nursing to revamp history forms. We set a go live date and made our workflow to be that all patients coming through the door after the go live date would need to update their patient history forms to. This was done to increase the rate of depression and substance abuse screening.

Our story

- MCHC utilized our quality and data team to plan the update of our patient history forms. The Chief Medical Officer was highly involved and led the change process. Forms were revised to more accurately capture patient data that was needed to formulate a Comprehensive Health Assessment. Since MCHC is in the midst of a PCMH 2014 application process we utilized those standards to guide our work. Nursing staff was highly crucial to the change process. The data team held site trainings to orient the Nursing staff to the new patient history forms and workflow.

Our data ! PHQ-9 screenings

Depression Screening and Follow-Up



Peggy Keating, VP of Behavioral Health and Care Integration and Maryann Kuzila, Associate Director of Behavioral Health

Neighborhood Family Practice

Five locations in Greater Cleveland area

Action Item

What aspect of your action plan do you want to highlight?

Roll out of SBIRT to all five sites

The who, what and why

August 2015 - Began with two teams (purple and red) at Ridge location

January 2016 – Puritas (orange)

May 2016 – W. 117th (coral)

July 2016 – DSO (yellow) and Ridge (blue team)

August 2016 – Tremont (green) and Ridge (turquoise)

Tell us your story

We want to hear about how you did it!

- June 2015 – agency-wide meeting to introduce and explain SBIRT to all staff
- Initially, three disciplines were trained – MAs, nurses and BH dept
- After that, trained two multi-disciplined Ridge teams
- Continued with training teams versus disciplines

Graduated schedule of roll-out in each team:
- First week – two hours
- Second week – ½ day
- Third week – full day

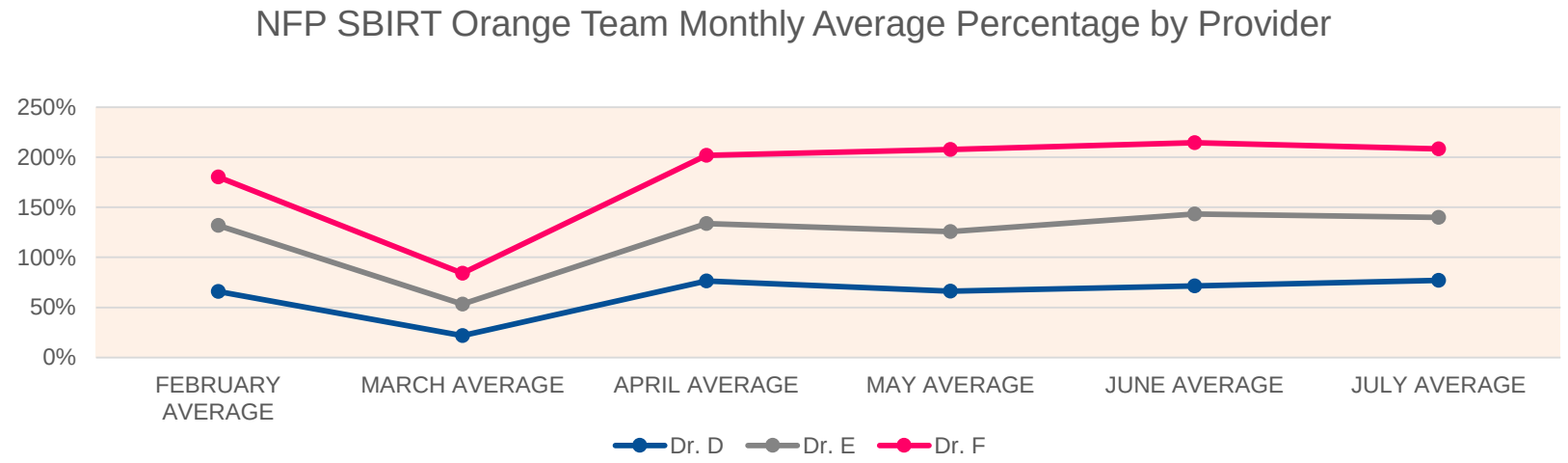
Sites were given clipboards designated to be used for SBIRT questionnaires. Cover page was used to protect confidentiality. Staff was instructed to keep clipboards loaded with SBIRT pre-screening questionnaire to encourage compliance and increase readiness

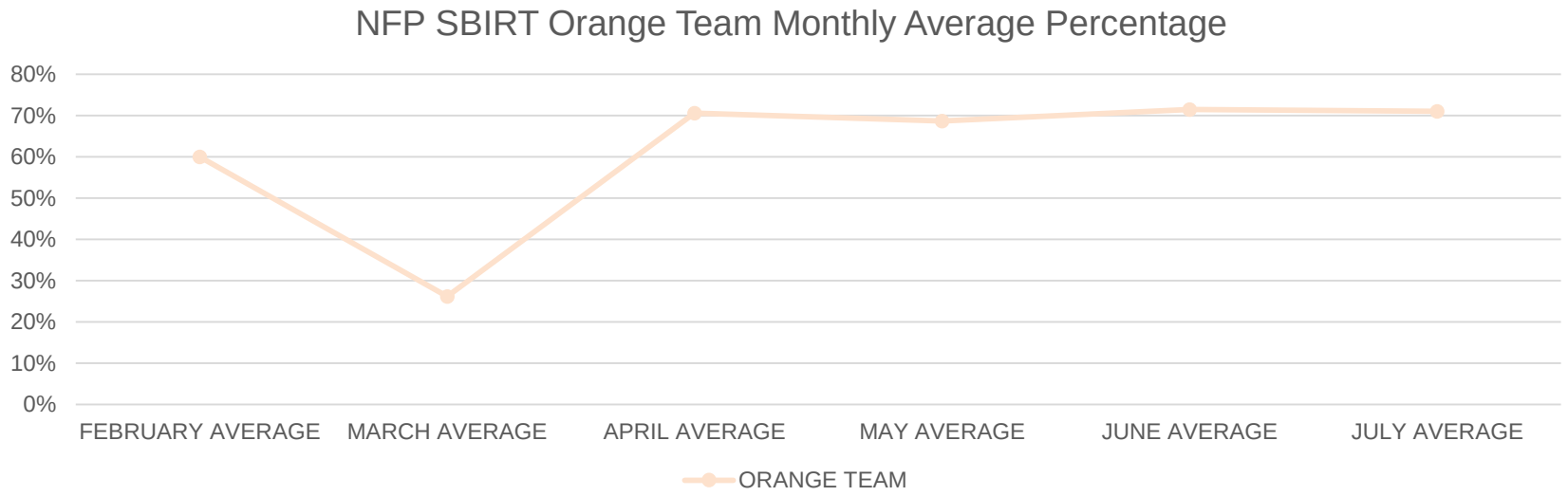
<u>Challenges</u>
- Losing momentum between August 2015 and January 2016 trainings
- Balancing staff ideas with necessary adherence to SBIRT requirements (e.g. provider created his own form, but could not accommodate request to alter DAST/AUDIT)

How do you use your individual and organizational creativity and uniqueness to solve, overcome, change, influence, implement? --

- Found that SBIRT team needed to meet regularly and consistently to plan trainings and implementation.
- Incentivized teams to encourage them to meet goals (e.g. if met goal (90%), each team member was awarded a tablet)
- When necessary, had follow up discussion of SBIRT during monthly team meetings to inform team of their progress and address any outstanding questions and/or concerns
- Linkage coordinator offered on-site support for teams during roll-out periods. Included providing support, assistance, answering questions, dealing with individualized concerns

DATA


NFP SBIRT Orange Team Monthly Average Percentage by Provider
250%
200%
150%
100%
50%
0%
FEBRUARY AVERAGE
MARCH AVERAGE
APRIL AVERAGE
MAY AVERAGE
JUNE AVERAGE
JULY AVERAGE
Dr. D
Dr. E
Dr. F


NFP SBIRT Orange Team Monthly Average Percentage
80%
70%
60%
50%
40%
30%
20%
10%
0%
FEBRUARY AVERAGE
MARCH AVERAGE
APRIL AVERAGE
MAY AVERAGE
JUNE AVERAGE
JULY AVERAGE
ORANGE TEAM

Northeast Valley Health Corporation

a california health+ center

Yolanda Cespedes-Knadle, Ph.D.
Director of Behavioral Health Coordinator

Arlyn Hernandez, B.A.
Behavioral Health Program

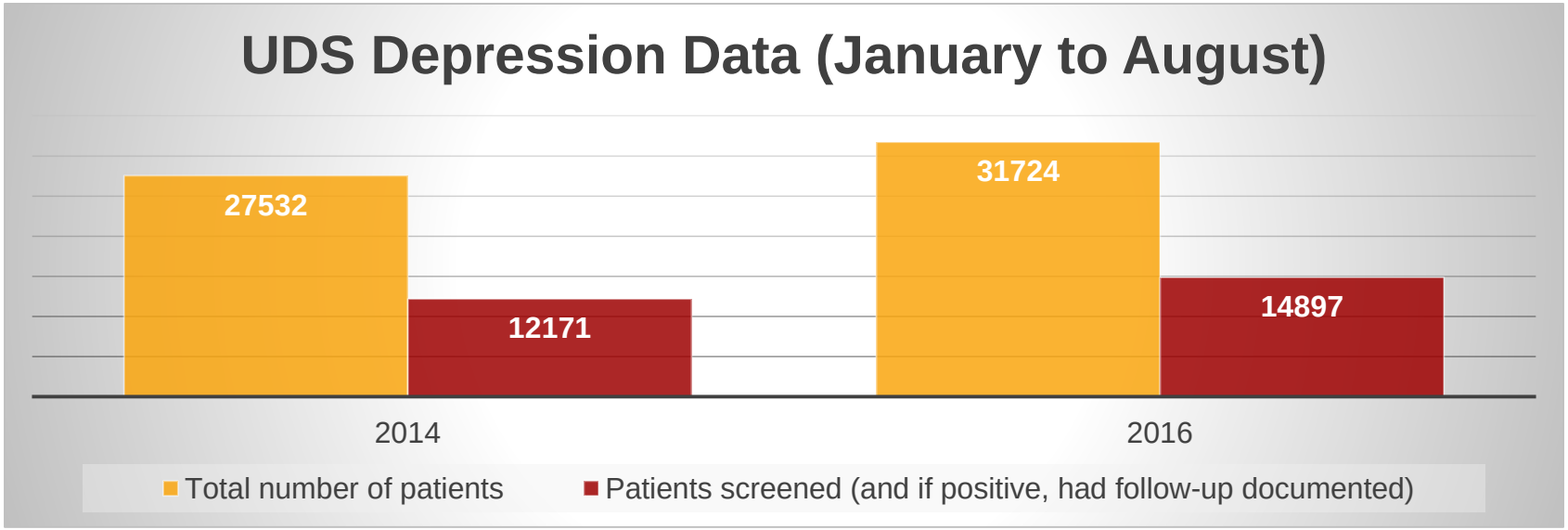
Our Mission

The mission of Northeast Valley Health Corporation is to provide quality, safe and comprehensive healthcare to the medically underserved residents of Los Angeles County, particularly in the San Fernando and Santa Clarita Valleys, in a manner that is sensitive to the economic, social, cultural and linguistic needs of the community.

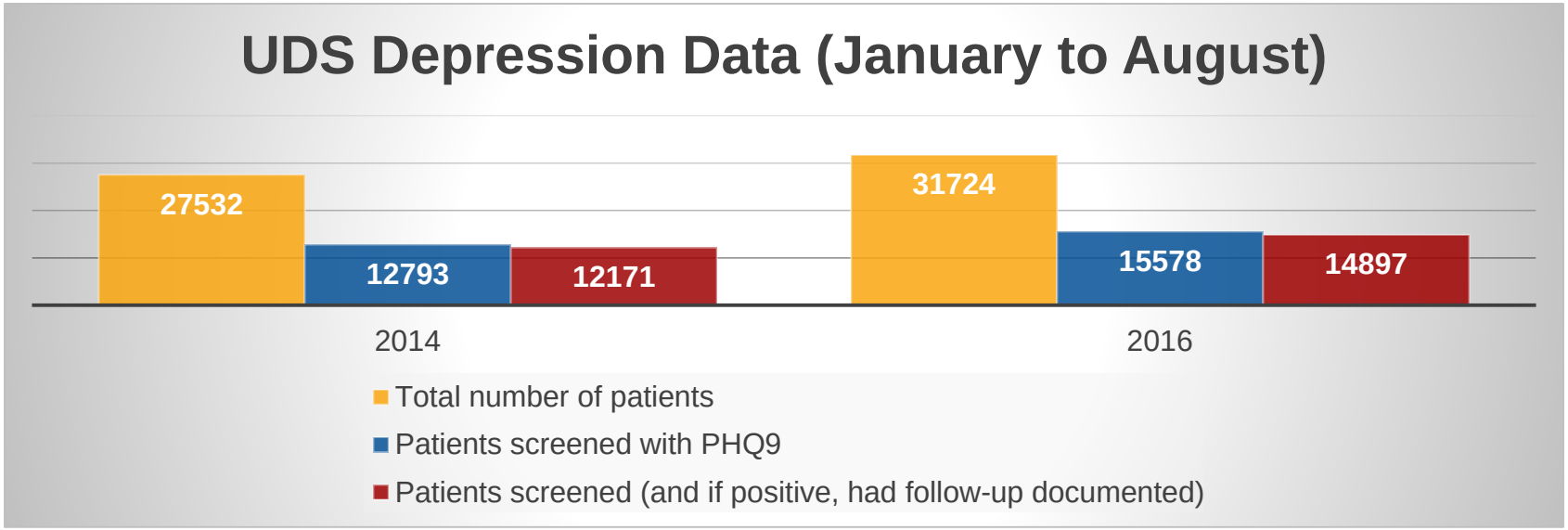
SBIRT at Northeast Valley Health Corporation

- WHO: Everyone age 12 and over
- WHAT: PHQ-9
- WHERE: Primary care centers and specialty population programs
- WHEN: Annually at medical visits and during any new intake with Behavioral Health (BH)
- HOW: Administered by clinical support staff or BH provider, follow-up on positive screens by medical or BH provider

A look at the data…



A closer look at the data…



What story does the data tell?

- Overall numbers and percentages are increasing over time
- Improving UDS measure requires improved screening rather than improved follow-up on positive screens

Continuing to troubleshoot:

- Capturing the data for follow-up documentation (e.g., still working to map areas where BH documents)

The journey continues…

SBIRT for substance use will launch October 1st

Learning points from SBIRT for depression:

- Developing the workflow (WHO, WHAT, WHERE, WHEN, HOW)
  - Training clinical support staff on administration and scoring
  - Training medical providers on brief intervention
- Integrating the screeners into the EHR
- Capturing the data (e.g., brief intervention) and mapping the EHR

PrimaryOne Health

Your first choice for quality care

Our Mission:

To provide and promote access to quality healthcare and related services to individuals and families in the Columbus community neighborhoods

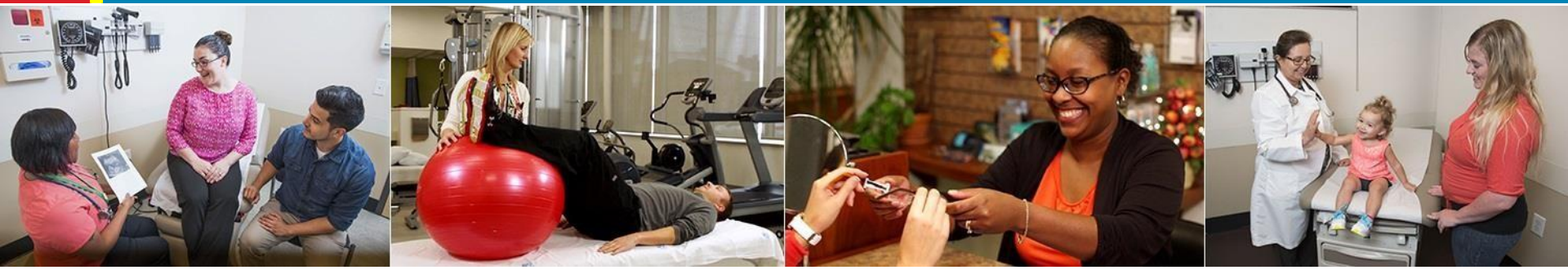
Staci Swenson, MA, MSW, LISW-S
Integrated Care Manager

August 24, 2016

Level 3 Patient-Centered Medical Home

Recognized by the National Committee for Quality Assurance as a Level 3 Patient-Centered Medical Home

Services we provide



OB/GYN

Primary Care & Pediatrics

Dental Services

Vision Services

Behavioral Health

Adult and Internal Medicine

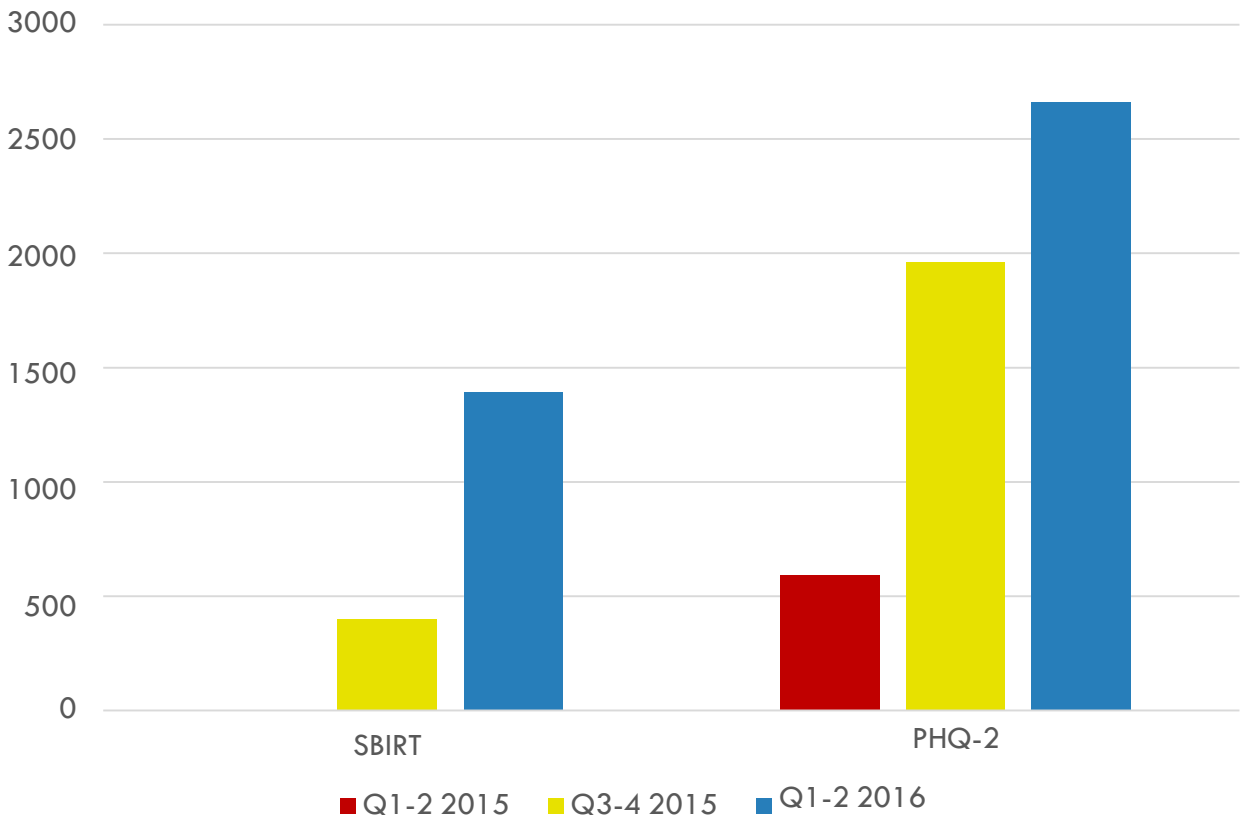
Specialty Care Services (PT, Cardiology, Gastroenterology)

Health Care for the Homeless

Our journey with data

- December 2015
- "Junk in…junk out…"
  - What we were doing versus what the data said we were doing
  - Thank you Innovation Community program!

SBIRT and Depression Screenings



Moving Forward

- Working with BH team, RN Clinical Care Coordinators, and MAs to increase number of screenings performed
- Working with each site to streamline processes for screening and providing treatment
- Working with data analysts to improve quality of the data

Michelle W. Lewis, MSW, LCSW
Roanoke Chowan Community Health Center
Ahoskie, NC

Serving Bertie, Gates, Hertford, Northampton, and Washington Counties

Action Item

During the course of the this project, ***can you believe that Depression screening actually decreased? We went from 75% as an agency in Nov 2015 to 60% in Mar 2016.***

Therefore, our Action items we had previously formulated had to be re-prioritized! Welcome to Real Life.. ☺

Contributors to decreased screening:

- **Staff turnover**
- **Implementation of Team Based Care**
- **Focus on other Health Maintenance issues (Colorectal Screening, etc)**

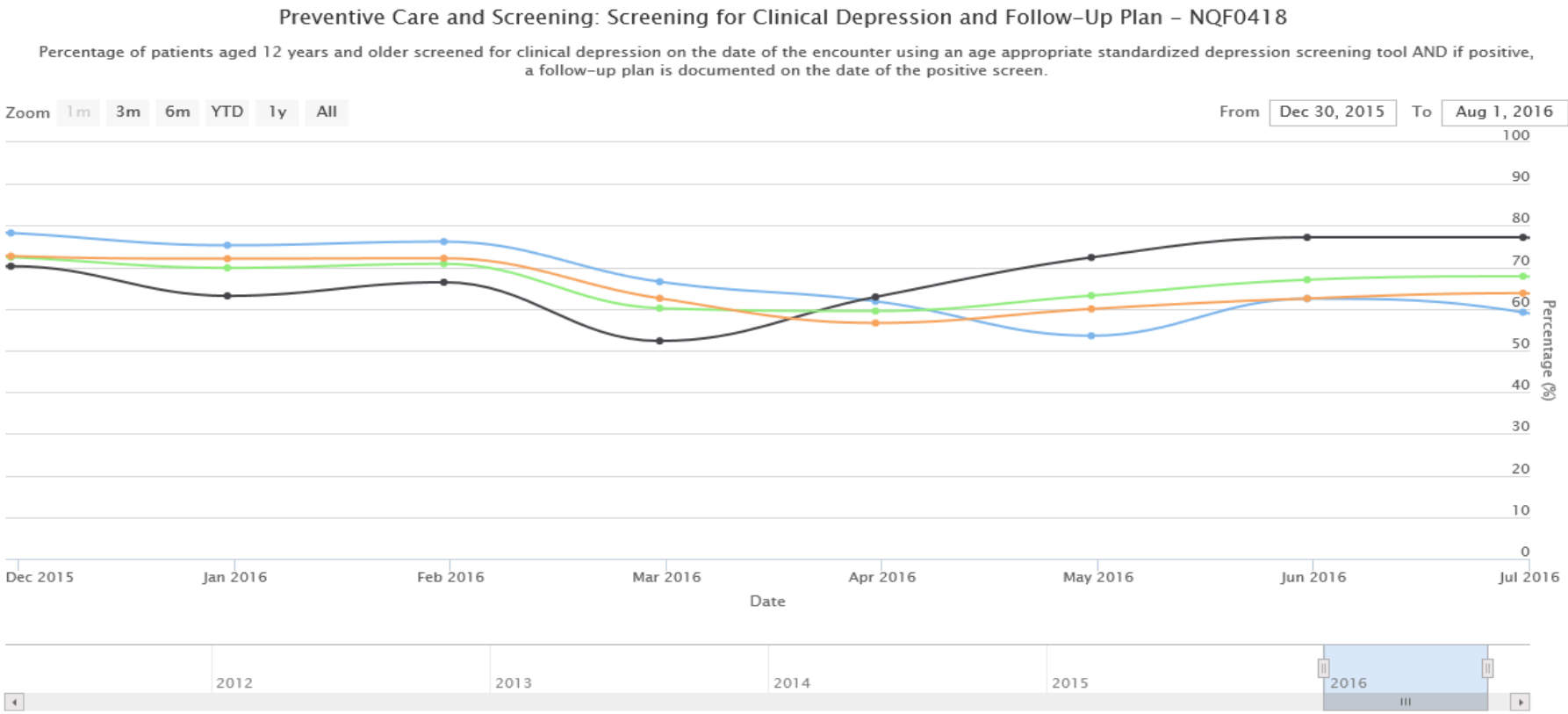
RCCHC's Story

- After the downward trend was noticed at the end of March, the BH Integrated Care Specialist reviewed Providers daily schedule and added note if Depression screening was due.
  - Helped staff remember this item with all of the other many "items" they have
  - Most were appreciative-- ☺
- This intervention has been effective at improving our screening from March to July.
  - Agency (as a whole) improved 7%
  - MPC site improved 25 %
  - ACC site improved 1%
  - CPC site decreased 5%

RCCHC's Story– Next Steps

- 8/15/16---We have revised our workflow yet again, with the goal of surpassing our highest 75% Depression Screening rate obtained in Nov 2015, as well as to be as efficient with staff time as possible.

- Administrative staff has been included in the workflow.
  - They are alerted when a patient's Depression Screening is due
  - Staff provide patient with age appropriate Depression screening for completion while they wait to be called back for appointment with provider
  - Depression screening is given to Medical/nursing staff


Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – NQF0418
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Zoom 1m 3m 6m YTD 1y All
From Dec 30, 2015 To Aug 1, 2016
100
90
80
70
60
50
40
30
20
10
0
Percentage (%)
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Date
2012
2013
2014
2015
2016

	Date	Denominator	Dimension	Metric	Numerator	Percentage (%)
NQF0418	07/31/2016	1278	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	815	63.77%
NQF0418	06/30/2016	1595	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	997	62.51%
NQF0418	05/31/2016	1520	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	912	60.00%
NQF0418	04/30/2016	1547	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	876	56.63%
NQF0418	03/31/2016	1578	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	987	62.55%
NQF0418	02/29/2016	1412	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	1019	72.17%
NQF0418	01/31/2016	1310	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	944	72.06%
NQF0418	12/31/2015	1333	ROANOKE CHOWAN COMMUNITY HEALTH CENTER-AHOSKIE (fac)	NQF0418_CMS2v4_AQLv3	969	72.69%
NQF0418	07/31/2016	2039	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1383	67.83%

NQF0418	06/30/2016	2521	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1689	67.00%
NQF0418	05/31/2016	2416	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1527	63.20%
NQF0418	04/30/2016	2439	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1451	59.49%
NQF0418	03/31/2016	2496	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1502	60.18%
NQF0418	02/29/2016	2246	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1591	70.84%
NQF0418	01/31/2016	2083	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1455	69.85%
NQF0418	12/31/2015	2175	ROANOKE CHOWAN COMM HLTH CTR (org)	NQF0418_CMS2v4_AQLv3	1575	72.41%
NQF0418	07/31/2016	504	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	389	77.18%
NQF0418	06/30/2016	609	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	470	77.18%
NQF0418	05/31/2016	626	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	453	72.36%
NQF0418	04/30/2016	633	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	398	62.88%
NQF0418	03/31/2016	673	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	352	52.30%
NQF0418	02/29/2016	646	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	429	66.41%
NQF0418	01/31/2016	594	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	375	63.13%
NQF0418	12/31/2015	649	MURFREESBORO PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	456	70.26%

NQF0418	07/31/2016	174	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	103	59.20%
NQF0418	06/30/2016	237	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	148	62.45%
NQF0418	05/31/2016	211	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	113	53.55%
NQF0418	04/30/2016	207	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	128	61.84%
NQF0418	03/31/2016	248	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	165	66.53%
NQF0418	02/29/2016	193	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	147	76.17%
NQF0418	01/31/2016	182	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	137	75.27%
NQF0418	12/31/2015	202	COLERAIN PRIMARY CARE (fac)	NQF0418_CMS2v4_AQLv3	158	78.22%

Tri-Town Community Action Agency

Health Center

Jody Cloutier

Johnston RI

Action Item: To improve treatment planning and treatment follow-up for patients who have a positive depression screen.

Goal: To increase effectiveness of follow-up procedures by having a functioning registry to track all patients with a positive screen.

Development of a registry to track patient data regarding positive screening results for depression, anxiety and substance use screening.

Track all patients ages 12 and up on a registry modeled from the AIM Center.

The IBH team worked with the AIM Center to develop a registry that would assist our team in tracking and providing follow-up to patients who have positive depression, anxiety and substance use screenings.

On June 7th, 2016 IBH staff began entering data into the registry. All positive screens were added with patient information, provider plans from visit (counseling referral, introduction of medications etc), and follow-up information.

IBH staff utilize the data on the registry to inform pre-visit planning and morning huddles to ensure that patients that have been identified with positive screening results are screened at every follow-up appointment with their provider.

The IBH Coordinator reviews the registry on a weekly basis to look at screening results, follow-up rates, and patient follow-through on referrals.

As of August 22nd there are 193 patients on the registry.

Tri-Town Community Action Agency - Patient Tracking Tool_with CAGE and Diagnosis - Excel

Jody Cloutier

Name	Treatment Status	Current Diagnosis Code(s)	Display (Hide past tx episodes or view only the most recent contact)	Tickler	Episode Number	Follow-up Contact Number	Date Follow-up Due	Actual Contact Dates	Type of Contact	PHQ-9 Score (Target is < 5 within 5-7 months of initial elevated PHQ-9)	% Change in PHQ-9 score (Target is -50% within 5-7 months of initial elevated PHQ-9)	GAD-7 Score (Target is < 10 within 5-7 months of initial elevated GAD-7)	% Change in GAD-7 score (Target is -50% within 10 weeks of tx initiation or change)	CAGE Score	% Change in CAGE score	Psychotropic Medication(s)	Treatment Plan	Care Manager Contact Notes and Flag for Psychiatric Case Review (Include notes about appointment reminder calls, referrals to specialty services, etc.)	Date of Psychiatric Case Review (Date of most recent Psychiatric Case Review automatically populates at top)
	Active				0	Current Episode Initial Assessment	2-week follow-up schedule		Clinic	No score		no score		no score					

Disclaimer | Patient Tracking | Caseload Overview

READY

integration.samhsa.gov

Next Steps

IBH staff to begin contacting patients who have not been into the health center for a follow up appointment with their medical or behavioral health provider within six months to complete a follow-up screening.

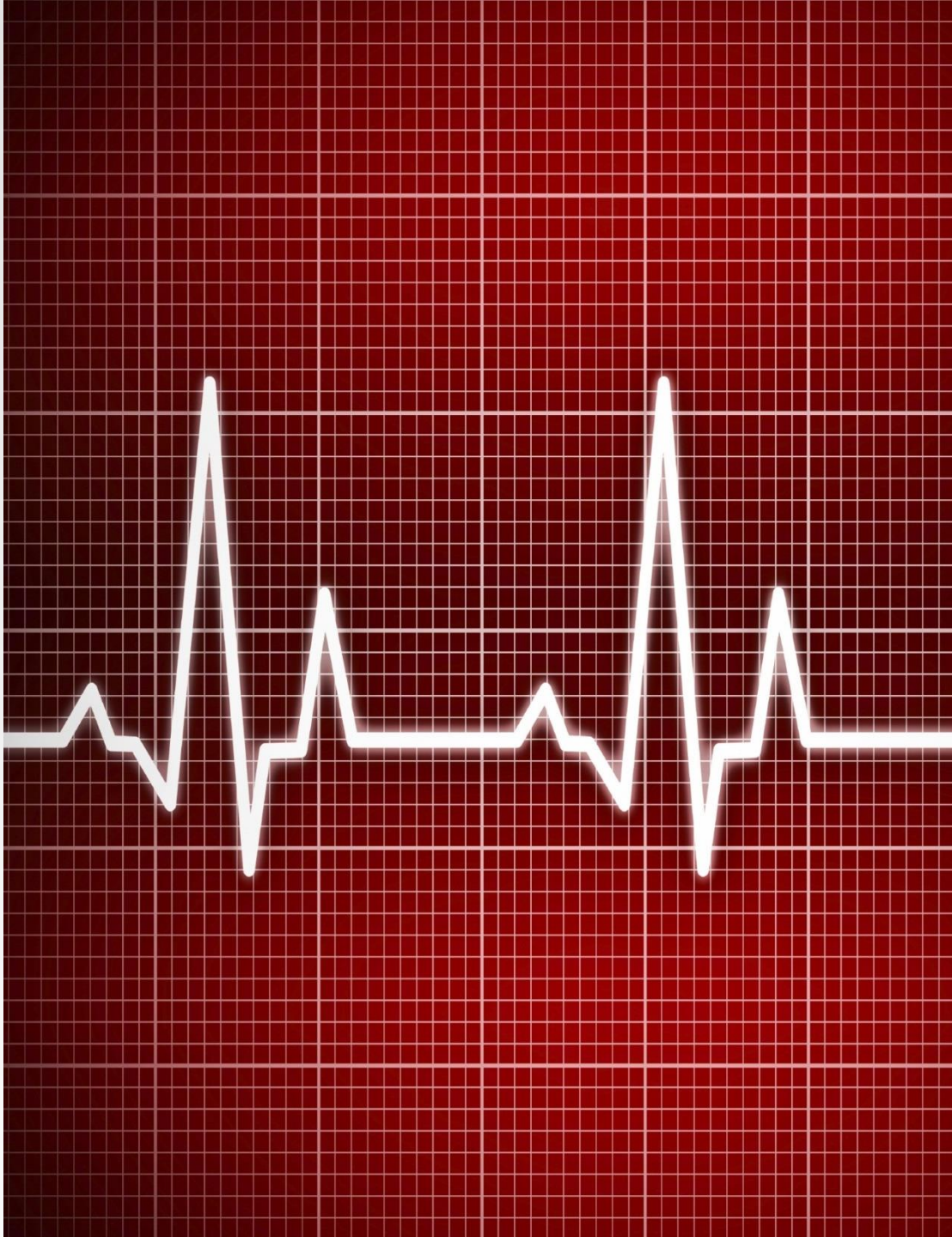
The Wellness Program at the Mountain

Danny C. Gilmore, Jr.,MHS
Behavioral Health Administrator

WELSH MOUNTAIN HEALTH CENTERS

NEW HOLLAND, PA

AUGUST 24, 2016



The Wellness Program at the Mountain

- Close collaboration in a fully integrated system where a team base, integrated model of care is employed using predetermined protocol that incorporates a Wellness Program within the primary care delivery model.
- Provide training to support integration of primary medical and Wellness health care and the use of SBIRT and other evidence base practices.
- The stigma associated with mental/behavioral health promoted a new change for our behavioral health providers to Wellness Coaches.
- Patients with risk factors such as diabetes and hypertension are more comfortable having a session with a Wellness Coach.

The Wellness Program at the Mountain

- Patient Health Questionnaire-9 is the tool utilize to screen patients
- The increase in screens has impacted the overall health of the patient.
- Patients have become active participants in the continuity of care for treatment.
- Increased the team approach to treating patients at the Mountain.

	2015	2016
PHQ-9	1625	2558

The Wellness Program at the Mountain

- The data becomes knowledge when the provider and the Wellness coach drills down and discovers the behavioral changes that need to be made to help the patient.
- A patient was experiencing depression like symptoms because he could NOT keep his dog at his apartment.
- The Wellness coach help him get the dog back.
- The patient has not had a repeat visit to his primary care physician nor has he been to the Emergency Room.

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Questions?

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Thank you for joining us today. Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

If you have additional questions/comments please send them to:

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